

SENATE BILL No. 295

DIGEST OF INTRODUCED BILL

Citations Affected: IC 27-13-36-5; IC 27-13-36-9; IC 27-13-36.2-4.

Synopsis: HMO payments to providers. Requires health maintenance organizations (HMOs) to pay out of network providers (following referral) and emergency providers the lowest of: (1) the providers' billed charge (instead of the usual, customary, and reasonable charge for the HMO's service areas); (2) the Medicare participating provider allowable amount; or (3) an agreed amount.

Effective: July 1, 2002.

Johnson

January 7, 2002, read first time and referred to Committee on Health and Provider Services.

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Second Regular Session 112th General Assembly (2002)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 2001 General Assembly.

SENATE BILL No. 295

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

1 SECTION 1. IC 27-13-36-5 IS AMENDED TO READ AS
2 FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 5. (a) The provisions
3 of the section do not apply until July 1, 1999.

4 (b) When an enrollee's primary care provider determines that the
5 enrollee needs a particular health care service and the health
6 maintenance organization determines that the type of health care
7 service needed by the enrollee to treat a specific condition:

8 (1) is a covered service; and

9 (2) is not available from the health maintenance organization's
10 network of participating providers;

11 the primary care provider and the health maintenance organization
12 shall refer the enrollee to an appropriate provider who is not a
13 participating provider within a reasonable amount of time and within
14 a reasonable proximity of the enrollee.

15 (c) When an enrollee receives health care services from a provider
16 to whom the enrollee was referred as described in subsection (b), the
17 health maintenance organization shall pay the out of network provider



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the ~~lesser~~ **least** of the following:

(1) The ~~usual, customary, and reasonable charge in the health maintenance organization's service area for the health care services provided by the out of network provider~~ **provider's billed charge.**

(2) **The Medicare participating provider allowable amount under 42 U.S.C. 1395 et seq.**

(3) An amount agreed to between the health maintenance organization and the out of network provider.

The enrollee's treating provider may collect from the enrollee only the deductible or copayment, if any, that the enrollee would be responsible to pay if the health care services had been provided by a participating provider. The enrollee may not be billed by the health maintenance organization or by the out of network provider for any difference between the out of network provider's charge and the amount paid by the health maintenance organization to the out of network provider as provided in this subsection.

(d) A contract between a health maintenance organization and a primary care provider may not provide for a financial or other penalty to the primary care provider for making a determination allowed under subsection (b).

SECTION 2. IC 27-13-36-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 9. (a) As used in this section, "care obtained in an emergency" means, with respect to an enrollee, covered services that are:

(1) furnished by a provider within the scope of the provider's license and as otherwise authorized under law; and

(2) needed to evaluate or stabilize an individual in an emergency.

(b) As used in this section, "stabilize" means to provide medical treatment to an individual in an emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of the individual's condition is not likely to result from or during any of the following:

(1) The discharge of the individual from an emergency department or other care setting where emergency services are provided to the individual.

(2) The transfer of the individual from an emergency department or other care setting where emergency services are provided to the individual to another health care facility.

(3) The transfer of the individual from a hospital emergency department or other hospital care setting where emergency services are provided to the individual to the hospital's inpatient

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1 setting.

2 (c) As described in subsection (d), each health maintenance
3 organization shall cover and reimburse expenses for care obtained in
4 an emergency by an enrollee without:

5 (1) prior authorization; or

6 (2) regard to the contractual relationship between:

7 (A) the provider who provided health care services to the
8 enrollee in an emergency; and

9 (B) the health maintenance organization;

10 in a situation where a prudent lay person could reasonably believe that
11 the enrollee's condition required immediate medical attention. The
12 emergency care obtained by an enrollee under this section includes
13 care for the alleviation of severe pain, which is a symptom of an
14 emergency as provided in IC 27-13-1-11.7.

15 (d) Each health maintenance organization shall cover and reimburse
16 expenses for emergency services at a rate equal to the ~~lesser~~ **least** of
17 the following:

18 (1) ~~The usual, customary, and reasonable charge in the health~~
19 ~~maintenance organization's service area for health care services~~
20 ~~provided during the emergency: provider's billed charge.~~

21 (2) **The Medicare participating provider allowable amount**
22 **under 42 U.S.C. 1395 et seq.**

23 (3) An amount agreed to between the health maintenance
24 organization and the ~~out of network~~ provider.

25 A provider that provides emergency services to an enrollee under this
26 section may not charge the enrollee except for an applicable copayment
27 or deductible. Care and treatment provided to an enrollee once the
28 enrollee is stabilized is not care obtained in an emergency.

29 SECTION 3. IC 27-13-36.2-4, AS ADDED BY P.L.162-2001,
30 SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
31 JULY 1, 2002]: Sec. 4. (a) A health maintenance organization shall pay
32 or deny each clean claim as follows:

33 (1) If the claim is filed electronically, not less than thirty (30) days
34 after the date the claim is received by the health maintenance
35 organization.

36 (2) If the claim is filed on paper, not less than forty-five (45) days
37 after the date the claim is received by the health maintenance
38 organization.

39 (b) **Except as provided in subsection (c), if:**

40 (1) a health maintenance organization fails to pay or deny a clean
41 claim in the time required under subsection (a); and

42 (2) the health maintenance organization subsequently pays the

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claim;
the health maintenance organization shall pay the provider that submitted the claim interest on the lesser of the usual, customary, and reasonable charge for the health care services provided to the enrollee, or an amount agreed to between the health maintenance organization and the provider paid under this section.

(c) **For a clean claim arising under IC 27-13-36-5 or IC 27-13-36-9, if:**

(1) **a health maintenance organization fails to pay or deny the clean claim in the time required under subsection (a); and**

(2) **the health maintenance organization subsequently pays the claim;**

the health maintenance organization shall pay the provider that submitted the claim interest on the provider's billed charge, on the Medicare participating provider allowable amount under 42 U.S.C. 1395 et seq., or on the amount agreed to between the health maintenance organization and the provider paid under this section, whichever is least.

(d) Interest paid under subsection (b) or (c):

(1) accrues beginning:

(A) thirty-one (31) days after the date the claim is filed under subsection (a)(1); or

(B) forty-six (46) days after the date the claim is filed under subsection (a)(2); and

(2) stops accruing on the date the claim is paid.

~~(d)~~ (e) In paying interest under subsection (b) or (c), a health maintenance organization shall use the same interest rate as provided in IC 12-15-21-3(7)(A).

SECTION 4. [EFFECTIVE JULY 1, 2002] **IC 27-13-36-5, IC 27-13-36-9, and IC 27-13-36.2-4, all as amended by this act, apply to payment by a health maintenance organization of a claim for health care services provided to an enrollee after June 30, 2002, by:**

(1) **an out of network provider; or**

(2) **a participating provider under a contract with the health maintenance organization that is entered into, amended, or renewed after June 30, 2002.**

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